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Michael F. Easley, Governor
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Richard J. Visingardi, Ph.D, Director

November 13, 2003

MEMORANDUM

To: Legislative Oversight Committee Members
MH/DD/SAS Commission
Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
North Carolina Council of Community Programs
Area Program Directors
Area Program Board Chairs
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Richard J. Visingardi, Ph.D.

Re: **Communication Bulletin # 013**
Systems Management

Over the past few months, a considerable amount of time and attention has been devoted to the issue of case management, e.g., what does it mean, who should provide it, how should it be provided, etc. Much of this attention has been precipitated by the MH/DD/SAS reform design direction that assigns responsibility for the provision of case management to the provider network, rather than to the LMEs. This design direction has created considerable concerns among area/county programs, in part, because many of the functions generally associated with case management are viewed as integral to the ability of the area/county programs to manage the public MH/DD/SAS system.

Equally important to understanding the issues associated with the divestiture of case management is a clear definition and delineation of the functions of case management. For purposes of clarification, case management is defined as a direct, individual client service. Case management includes individual client assessment, service planning, and implementation. It is the process through which the service plan is monitored and coordinated among multiple agency or individual providers. Case management assists and advocates for the client as the client traverses the formal treatment/support system and the informal system of natural supports. These functions are consistent with the various models of case management as defined in the literature.

As a means of advancing the discussion, a clear distinction between service delivery related case management and the LME functions of systems management is needed. The following is a two component summary of systems management:

- **Service Management:** This includes the authorization, utilization management and care coordination functions. Responsibilities in these areas include assuring that person-centered plans are appropriate, providing clinical review of "outlier" and high-risk circumstances and cases, and enhanced clinical involvement in complex cases, as key examples. On a case level, these functions serve to monitor and guide the case management functions of assessment, planning, implementation and monitoring.

- **Systems Management:** This includes the service management function as well as the provider network management, customer services and community coordination/collaboration functions. Within a quality management framework, responsibilities in these areas include performance monitoring of the providers, providing a complaint and grievance system for consumers, and to engage community partners in efforts of supporting people with disabilities and their families, as key examples. On a systems level, these functions support efforts related to planning, implementation, evaluation and monitoring.

In addition, the access system includes the screening, triage and referral functions. These functions are intended to promote a consumer and community friendly and timely system of access for services. Furthermore, the community crisis system and crisis services ensure that urgent needs are immediately and appropriately addressed.

As our collective understanding of LME systems management advances, as well as our developing the new services that reflect best practices in replacing our current case management models of practice, concerns regarding the divestiture of case management should diminish. Factors that should ultimately shape concerns include:

- **LME Role:** The level of policy support regarding the necessary LME responsibilities and corresponding authority to assume the role of systems manager. The LME will need to have a sufficient management role. The memorandum from Visingardi and Fuquay, dated October 22, 2003 (Subject: Policy Agreements Regarding New Mental Health, Developmental Disabilities and Substance Abuse Benefits and Benefit Packages), provides the foundation policy support necessary for LMEs to assume responsibility and corresponding authority as systems managers.

- **Models of Practice:** The comprehensive nature of the models of practices (Assertive Community Treatment Teams, Community Support Teams, Community Support Programs, Home-Based, as key examples) require a range of clinical and support competency and expertise.

- **Provider Organizations:** The level of expectations of the organizational capacity as described in qualification and certification standards. These provider organizations will need to demonstrate capacity and competency.

- **Finance Fidelity:** The payer's requirements to ensure that the service delivery models are clearly distinct from the systems management functions. The integrity of the boundary of financing services and systems management must be distinguishable and maintained.

There is recognition that most of the area/county programs are developing the organizational capacity to manage the highly decentralized service delivery system envisioned by the reform effort. This includes developing capacity in information systems, staff competencies, and a highly developed Quality Improvement/Quality Assurance (QI/QA) system. In the short term, some programs might need to rely on their case management functions to carry out parts of the system management function. If this is the case, area/county programs can submit justification to the Department, through their local business plan, and receive Departmental approval to continue to provide case management on a time-limited basis. This will allow the program(s) additional time to develop the mechanisms necessary to manage their local public mental health, developmental disabilities and substance abuse services system. In addition, we do anticipate that it will take some time for the development of providers who are qualified to implement the new models of practice. As stated in State Plan 2003, the LMEs divestiture plan is dependent on appropriate community capacity.

Any questions regarding this communication should be directed to:

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Thank you

cc: Secretary Carmen Hooker Odom
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MH/DD/SA Staff